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House Human Services Committee
via email to Committee Clerk Courtney DeBower, Courtney.DeBower_HC@house.texas.gov

Chairman Frank and House Human Services Committee Members,

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related health care entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

We are writing to provide information in response to your RFI regarding health care access and Medicaid. Over the past 20 years, Texas has transformed a costly, outdated, and broken Medicaid program into an affordable, modern, and personalized health insurance program by leveraging private sector innovation and community collaboration.

Under the old Medicaid fee-for-service (FFS) program, HHSC contracted with a private company to administer the program and pay health care providers for every service delivered. The contractor was paid for each transaction, was not responsible for coordinating care or keeping Texans healthy and out of the hospital, and was not at financial risk for more expensive care due to poor health outcomes. It was difficult for patients to find doctors, and they were forced to wait until they got sick to receive care — often ending up in the ER. Older Texans and Texans with disabilities in need of care were forced out of their homes and communities and into nursing facilities. The lack of real accountability led to fraud and abuse, uncontrollable spending, and clients seeking care in ERs.

To address these problems, Texas and other states tested various models before determining managed care was the best. Facing unprecedented budget issues in 2003, the Legislature directed HHSC to explore cost containment through the operation of a program called Primary Care Case Management (PCCM), similar to a direct primary care model. Under the program, each client was assigned to a single primary care provider who was responsible for approving and monitoring their care, typically for a small monthly case management fee in addition to FFS reimbursement for treatment. Unlike MCOs or physician capitation models, physicians in PCCM bear no financial risk for the services they provide or approve, and there is no budget certainty. During this time, HHSC was operating the STAR Medicaid managed care program for the same population. In March 2012, Texas phased out PCCM and expanded STAR statewide because PCCM was not as cost efficient and did not provide the same budget certainty as the STAR program.
A similar program called the Integrated Care Model was put into place in 2005 so that the Legislature could find cost savings in Medicaid. It was basically a PCCM model for adults with

disabilities and was administered partly by a single plan and partly through FFS at the state agency. The plan was paid a case management fee and the long term services and supports (LTSS) were not at risk or included in the capitation rate. The fragmented model was far more costly than STAR+PLUS, and STAR+PLUS was implemented statewide after the program was ended in 2009.

In the 1990s, Texas also tried a direct primary care model (prepaid health plan model) in Travis county where the payment was partially capitated for certain services. The model did not work because the entity contracting with the state was not able to handle the complications of Medicaid financing, risk and reporting. Federal requirements complicate the ability to implement this type of model in Medicaid. For example, every Medicaid dollar must be spent on a Medicaid covered and authorized service, and must be reported and audited, creating a lot of risk and administrative burden. Additionally, physicians engaging in this type of model would need to be able to provide, or ensure clients can receive, every medically necessary service. There are ways though to utilize managed care and pay for quality contracts to incentivize and reward primary care physicians to improve client behaviors and health outcomes.

Like Texas, most states terminated their PCCM and direct primary care models and fully embraced the managed care model. Testing other models proved that managed care makes budgeting more predictable, uses taxpayer funds more efficiently, and promotes access to the right care at the right time. States initially focused managed care on providing hospital and physician coverage to mothers and children. Once they gained experience, states began leveraging health plans' successes to move more complex populations and services into managed care and create greater savings. Today, over two-thirds of American Medicaid beneficiaries are enrolled in a Medicaid managed care program. Forty states use Medicaid MCOs, over a dozen have 90+% of their Medicaid enrollees in a managed care model, and as of July 2019, 23 cover LTSS under MCO contracts.[1]

Because so many states have conducted managed care programs for years, there is growing evidence that demonstrates the model's advantages over other models. Managed care has saved states up to 20% when compared to FFS.[2] One report estimated that states would realize savings totaling over $6 billion in 2016.[3] In Ohio, managed care saved taxpayers 9-11% from 2013 to 2015 — an estimated $2.5 to $3.2 billion.[4] Arizona achieved $29.5 billion in program savings across a recent 5-year period.[5] In Texas, focusing on prevention, wellness, and care coordination — getting Texans the care they need to get health, stay healthy, and live in their communities has translated into fewer hospitalizations and lower costs for taxpayers. Texas has saved between $5.3 and $13.9 billion through the use of the Medicaid managed care program.[6]

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1 10 Things to Know about Medicaid Managed Care, Kaiser Health Foundation, December 2019.

2 Medicaid Managed Care Study completed by Lewin Group for AHIP. August 2019.

3 L Shugarman, J Bern and J Foster; The Value of Medicaid Managed Care. Health Management Associates, November 2015.

4 http://modernmedicaid.org/medicaid_solutions_ohio_managed_care/#:~:text=Medicaid%20Results%3A&text=Managed%20care%20now%20covers%20more,to%20%243.2%20billion%20in%20savings.

5 Arizona Medicaid Statistical Snapshot, July 2019.

6 HHSC Rider 61, Evaluation of Managed Care Report, conducted by Deloitte, 2018.

The managed care model allows MCOs to offer services to their clients that go beyond the doctor's office, including arranging transportation, coordinating meals, navigating challenges at school, and assisting with employment, to ensure clients can access needed care. Preventive care like vaccinations and routine primary care visits not only help keep Texans healthy, but also reduce costly hospitalizations and ER visits. Texas also saves money by capping MCOs' administrative spending and profits — 90 cents of every dollar is spent directly on care, resulting in a highly efficient program with some of the lowest administrative costs in the U.S.[7]

Before Texas moved most of its Medicaid clients into a managed care model, it was necessary for the state to find areas for cost containment. Over the years, HHSC Budget Riders directed the agency to find savings through making policy changes to therapy and durable medical equipment (DME) services; exploring other payment models; strengthening fraud, waste, and abuse (FWA) prevention; strengthening prior authorization requirements; increasing private duty nursing assessments; reducing payment for non-emergent ER visits; reducing providers' FFS rates; implementing value-based payments; changing neonatal payment coding; improving birth outcomes; increasing efficiencies in the vendor drug pharmacy; and carving more services into managed care. Given all these efforts and the movement to the more efficient managed care model, there are fewer areas for the state to find savings in the administration of Medicaid.

To further increase efficiency and control costs, TAHP recommends continuing to reform the system by embracing the innovation of the private market. Health care experts generally agree that FFS and PCCM payment models incentivize volume without necessarily promoting quality. Therefore, current healthcare quality strategy moves away from evaluating and compensating providers based on volume and instead bases compensation on the value of care provided. Implementation of these value-based contracting arrangements, also known as alternative payment models (APMs), encourages innovation that can help sustain the Medicaid program by focusing the entire system on quality and efficiency. Consequently, the state's contract requires MCOs and dental maintenance organizations to transition a percentage (which increases each year) of payments to their contracted providers into APMs. The goal is to reward providers for focusing on the quality of the care they deliver — not on volume.

APMs are most effectively and efficiently administered through managed care and can be structured in a number of ways that incorporate cost, consumer health outcomes, and consumer experience — with capitated models at the "most advanced" end of the scale. Under a capitated, or at-risk, arrangement, an MCO pays a provider a set amount per month whether the patient needs services or not. When clients stay healthier and need less treatment, providers make more money. Therefore, primary care providers are incentivized to coordinate care and improve health outcomes. APMs can be extremely complex and take time to negotiate because each party must agree to the terms, but the goal is to move more and more primary care providers into a capitated payment arrangement. We know primary care providers have the most influence on client decision-making and behaviors that can drive improved health outcomes and reduce costs long-term.

[7] HHSC Rider 61, Evaluation of Managed Care Report, conducted by Deloitte, 2018.

Another type of APM used in the private market, Medicare, and Medicaid programs is called a preferred provider arrangement, which is the use of high-value providers who have a track record of providing high-quality, cost-efficient care to patients.These arrangements are critical for MCOs to further improve quality, contain costs, and increase efficiencies in Texas. Relying on provider performance data, health plans can identify providers who deliver high-quality, efficient health care and implement strategies to direct care to those providers. Arrangements with DME suppliers are among the most common types of preferred arrangements used by Medicaid programs and commercial insurers across the country. These arrangements ensure clients use the appropriate product, increasing their quality of life, and decreasing other health complications such as falls, ulcers, and other common conditions that result in more costly care. **Texas currently has barriers to using preferred provider arrangements in the Medicaid program — the Legislature should direct HHSC to allow MCOs to use these arrangements to contain costs and improve quality of care.**

APMs help achieve many of the goals previous cost containment riders set forth — incentivizing quality care, reducing FWA, and reducing administrative burdens — without affecting client services or provider payment rates. APMs also encourage the use of higher-value services such as evidence-based preventive care while limiting unnecessary services. A study of a high-value network in California found that preferred provider arrangements resulted in 20% lower health care costs and 20% higher quality.[8] In a 2016 pilot program in Texas, one health plan entered into a preferred provider arrangement with a DME company for incontinence supplies and saw a 59.4% reduction in admissions for treatment of ulcers while reducing waste by identifying 675 patients receiving supplies at an old address.[9] APMs reward high-quality providers by incentivizing MCOs to waive certain administrative requirements those physicians consider burdensome. Performance-based payments also incentivize providers to improve their performance to become eligible for these types of arrangements in the future. **The Legislature should continue supporting the movement of managed care payments away from FFS and into APMs.**

As Texas looks for ways to contain costs, we encourage the state to continue embracing the proven managed care model and focus on paying for quality of care. I**n addition to supporting and encouraging APMs and preferred provider payment models, we submit the following potential cost savings ideas for consideration:**

1. **Make Medicaid look more like commercial coverage.** It is important for Texans no longer receiving Medicaid coverage to understand how to access and use commercial coverage. To further modernize and align the program with commercial coverage, which could also result in long term cost savings and increased client engagement, Texas could make several policy changes:
    - Limit client movement between MCOs in a single year – This will help providers adopt APMs, reduce provider recoupments, and improve continuity of care.
    - Auto-enroll clients in managed care on the first day of eligibility and eliminate temporary FFS enrollment – This will allow MCOs to start serving clients on day

[8] High Value Provider Networks. Milliman, July 2014.

[9] UnitedHealthcare and Longhorn Health Solutions Incontinence Supplies Capitation Program. December 2016.

one and immediately provide access to the services and care coordination needed to improve health outcomes. This would also reduce the reliance on and cost of an FFS contractor, as well as reducing costs at the Enrollment Broker vendor by allowing health plans, to assist clients with their primary care physician selection.

- Implement co-payments for non-emergent use of ER – HHSC never implemented this strategy that can help improve client behavior because it was difficult to do under FFS, but MCOs have the infrastructure to easily implement this initiative.

2. **Carve the remaining services into managed care**. This would improve coordination and health outcomes while achieving long term cost containment. Services for consideration include long term care for Texans with intellectual and developmental disabilities, hospice, the Healthy Texas Women program, and pharmacy services. HHSC released a study in 2017 showing that a full carve-in of pharmacy would have resulted in $20 million GR savings that year. This cost analysis included $30 million in premium taxes, but the ACA premium tax was recently repealed by Congress, resulting in a potential increased savings of $50 million GR per year. States that fully carve drugs into managed care realize savings because MCO formularies prefer lower-cost generics over brand names and cost 15% less than states that do not.[10] Integrating all medical care, behavioral health, prescription drugs, and other services ensures MCOs can coordinate the total care needed for better health outcomes.
3. **Address private duty nursing costs** by adopting policies that support the use of personal care services (attendant care) when more clinically appropriate and cost effective.
4. **Continue to reduce avoidable ER and urgent care visits through telemedicine and support the addition of the treat-in-place benefit in Medicaid**, which allows EMS providers to use telemedicine or divert to more appropriate settings. The current EMS model incentivizes transport to the ER without consideration for the most appropriate site. EMS agencies have been piloting this model with success and have proven savings through Delivery System Reform Incentive Payment (DSRIP) projects.
5. **Allow nursing facility statutory requirements that drive up costs to expire and adopt streamlined payment methodologies** that reduce administrative burden while recognizing quality (see TAHP response to the Human Services Committee's LTSS RFI).

Thank you for the opportunity to provide comments on improving the Medicaid program.

Sincerely,

Jamie Dudensing

Jamie Dudensing, RN
CEO, Texas Association of Health Plans
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[10] The Menges Group. Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States. April 2015.